PATIENT SAFETY FY2005

If you have any questions regarding patient safety you may contact Mr. Pete Nicholas, Risk Management Coordinator at 214-857-0456 or Lee Lewis Clinical Quality Management, Patient Safety Coordinator at extension 70417

1) The National Patient Safety Goals are based on actual sentinel events that have been reported to the Joint Commission on Accreditation of Healthcare Organizations. There are 10 patient safety goals for 2005:

1) correct patient identification
2) accurate communication
3) medication safety
4) wrong-site surgery
5) infusion Pumps
6) clinical alarm systems
7) healthcare-associated infections
8) reconciling medications
9) patient falls
10)flu and pneumonia immunization in older adults (Long Term care).

2) A Sentinel Event as defined by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) is an unexpected occurrence involving the death or serious physical or psychological injury, where a recurrence could result in a death or serious injury. Sentinel Events are not the result of any preexisting medical condition. Examples of Sentinel Events include death or serious injury following a medication error (wrong patient, wrong drug, wrong dosage, etc.) inpatient suicide, surgery or invasive procedure on the wrong patient or wrong site, or a severe blood transfusion reaction as a result of the wrong patient or wrong blood type being given. All staff are encouraged to report any actual or suspected Sentinel Event to their supervisor or the Patient Safety Hotline (extension 70456).

3) Root Cause Analysis (RCA) is a tool used by the VA to build a culture of safety for our veteran patients. The process involves a detailed review of why and how a sentinel or other serious patient related event has occurred. Periodic or aggregate root cause analyses are completed on patient falls, medication errors, missing patients and suicidal events. The RCA is designed to focus on opportunities to improve systems issues and not on individual employee performance. An interdisciplinary team is appointed by the VANTHCS Director to conduct a root cause analysis with the purpose of identifying any direct and or contributing causes to an event. Once the cause or causes of an event have been identified, the team determines whether the cause or causes should be accepted, controlled or eliminated based on practical recommendations or preventive strategies.

4) VA North Texas Health Care System (VANTHCS) employees may be asked to serve on a review team called Healthcare Failure Mode Effect Analysis (HFMEA). An HFMEA proactively reviews a system or a product to identify and prevent any potential failure or problem before it occurs. The HFMEA process includes the following elements:

1) an adequate description of the process, preferably through a flow chart
2) identification of the ways the process could break down (failure mode)
3) identification of the possible effects the breakdown or failure could have on the patient
4) prioritizing the potential breakdown or failures
5) redesigning the system or process to minimize the risk of effects on patient safety
6) testing of the redesigned system or process
7) starting the redesigned system and monitoring for effectiveness.

5) The National Patient Safety Goal on correct patient identification requires two (2) identifiers, which are the patient's first and last name and complete social security number. Room number or other location of the patient should not be used to identify the patient. Prior to the start of any surgical or invasive procedure, verification "time out" is required to confirm the correct patient, procedure, and site.

6) One National Patient Safety Goal is to improve the accuracy of communication among those who provide care to the patient. This goal can be met by doing three things:

1) read back orders or test results whenever such information is received verbally or by telephone
2) measure and see if anything needs to be changed to improve the timeliness of reporting critical laboratory results
3) standardize and publish a list of abbreviations and symbols that are not to be used at VA North Texas Health Care System (VANTHCS). The list of abbreviations not to be used is located in Medical Center Memorandum MR-1, Attachment A and in CRPS. The dirty dozen are common abbreviations that are unacceptable in the medical record: Examples of abbreviations not to be used include: "u" (write out the word "unit"),"MS" (write out the words "morphine sulfate") and "QD" (write out the phrase "everyday" or "daily").

7) Unacceptable abbreviations should not be used when ordering, prescribing or noting in the medical records because of the risk of being misinterpreted. Examples of unacceptable abbreviations are Morphine Sulfate (MS), Unit (U) and Everyday or Daily (QD).

8) Medication Safety, another National Patient Safety Goal, was initially designed to ensure that high alert medications such as concentrated electrolyte solutions (potassium) are not on ward stock. The new emphasis on medication safety includes monitoring and reducing errors associated with the following: look-alike, sound alike medications and high risk medications (insulin, anticoagulants and narcotics).

9) Reconciling Medications was a new National Patient Safety Goal for 2005. The aim of this goal is to make sure by 2006 that there is a process for obtaining and documenting a complete list of a patient's current medications upon admission. This would include all over the counter medications or supplements and medications received from sources outside of VA North Texas Health Care System (VANTHCS).

10) Reducing the number of falls and injuries of patients has always been a concern. The National Patient Safety Goal on Reducing the Risk of Falls requires that VA North Texas Health Care System (VANTHCS) assess and periodically reassess each patient's risk of falling to include the risk associated with the patient's medications.

11) A close call or near miss is an event or situation that could have resulted in an incident, injury or illness, but did not, either by chance or through timely intervention. An example of a close call would be a surgical or other procedure almost performed on the wrong patient due to lapses in verification of patient identification. Close calls are opportunities for learning and afford the chance to develop preventive strategies and actions.

12) Patient safety is a part of Clinical Quality Management Service at VA North Texas Health Care System (VANTHCS). All VANTHCS employees have a responsibility to report any actual or potential patient safety issues to Clinical Quality Management Service or to their supervisor as soon as possible. Reporting can be made anonymously. Reports can be made through a 24-hour Patient Safety Hotline (Extension 70417) or by a printed form, which can be found on the Quality Management website. The first employee who becomes aware of a patient incident or medication error should report the incident and forward it to Clinical Quality Management Service. Guidelines for Patient Safety at VANTHCS are found in Medical Center Memorandum PC-9.